MetLife

Continuation of Group Insurance for Disabled Dependent Child

For Continuation of Group Insurance for the Dependent Child due to Mental or Physical disabled.

Metropolitan Life Insurance Company

Things to Know Before You Begin

- **All sections *(Employer/Group, Employee and Physician)* are REQUIRED.**
- **Note:** Children who exceed the age limit prior to sustaining a mental or physical disabled are not eligible for coverage, nor are children who were not insured under the MetLife Group Policy prior to attainment of the plan's age limit, regardless of disabled status.

Answer all questions. Omitted information will cause delays.

SECTION 1: How to Submit This Form

Make a copy for your records & FAX or MAIL completed forms to:

Mail:
MetLife SOH Unit
PO Box 14069
Lexington, KY 40512-4069

Fax:
MetLife SOH Unit
1-859-225-7909

Email:
SOHSubmissions@MetLife.com

We're Here to Help

For inquiries, contact 1-800-638-6420, Prompt 1 *(Statement of Health Unit)* or email OADEligibility@metlife.com

SECTION 2: Employer's/Group's Statement - REQUIRED

To be Completed by Authorized Customer Representative.

Employee - First Name	Middle Name	Last Name

Social Security/ID Number	What Dependent coverage is this form being submitted for? ☐ Life ☐ Dental ☐ Vision

Employer/Group Name	Group Number

Sign Here

Signature of Authorized Customer Rep.	Title	Date *(mm/dd/yyyy)*

SECTION 3: Employee's Statement

First Request: ☐ **Yes** ☐ **No** | **Prior Request Date** *(mm/dd/yyyy)* _____

▶ Employee Information

First Name	Middle Name	Last Name

Address	City	State	ZIP

Social Security Number	Date of Birth *(mm/dd/yyyy)*	☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Phone Number

▶ Dependent Information

First Name	Middle Name	Last Name

Address	City	State	ZIP

Social Security Number	Date of Birth *(mm/dd/yyyy)*	☐ Male ☐ Female	Age	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Relationship to Employee

Is the Dependent permanently residing in Employee's household? ☐ Yes ☐ No

If No, explain:

Is the Dependent currently employed? ☐ Yes ☐ No

If Yes, complete the below Dependent Employer fields:

Current Dependent Employer Name

Dependent Employer Address	City	State	ZIP

If not now employed, give date last employed: Date *(mm/dd/yyyy)*	Estimated Income of Dependent From All Sources monthly	Percentage of Support of Dependent Supplied by Employee %

Employee Certifications and Signature

By signing below, I acknowledge:

1. All information I have given is true and complete to the best of my knowledge and belief.
2. Group insurance may be continued past the plan's age limit if the covered child is incapable of self-sustaining employment because of a mental or physical disabled. Proof of such disabled must be provided to MetLife within 31 days after the date the child attains the age limit. **Children who exceed the age limit prior to sustaining a mental or physical disabled are not eligible for coverage, nor are children who were not insured under the MetLife Group Policy prior to attainment of the plan's age limit, regardless of disabled status.**
3. I have read the applicable Fraud Warning(s) provided in this form.

Sign Here	Signature of Employee	Date *(mm/dd/yyyy)*

SECTION 4: Physician's/Surgeon's Statement *(Any fee for completion of this statement is to be paid by the Employee.)*

▶ **Patient's/Dependent's Information.** *(Pertaining to the disabled dependent)*

Date of Birth *(mm/dd/yyyy)* _____

First Name	Middle Name	Last Name

Is this Dependent presently incapable of self-sustaining employment by reason of:

Physical disabled?	Mental disabled?	Other *(Explain)*
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "other," explain: _____

Date Dependent became incapable of self-sustaining employment _____ Date *(mm/dd/yyyy)*

Diagnosis of Condition Causing Incapacity. Give as much detail as possible. Please give date and report of surgery, X-rays, electrocardiograms, or other special tests. Use separate sheet of paper if necessary.

Functional Age Level	Does the patient have a job?	Do you know what the patient's job is?	Do you know what duties the patient's job requires?
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Has this patient been able to do full or part-time work of any kind?	Will the patient be capable of self-support? If No, provide an explanation on a separate sheet of paper.
☐ No ☐ Yes from _____ Date *(mm/dd/yyyy)*	☐ No ☐ Yes from _____ Date *(mm/dd/yyyy)*

The patient is presently *(Check one)*

☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

Physician's/Surgeon's Signature

Physician's Information

First Name	Middle Name	Last Name

Address	City	State	ZIP

Sign Here	Signature of Physician/Surgeon	Phone Number	Date *(mm/dd/yyyy)*

MetLife

Fraud Warnings

Before signing this form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.